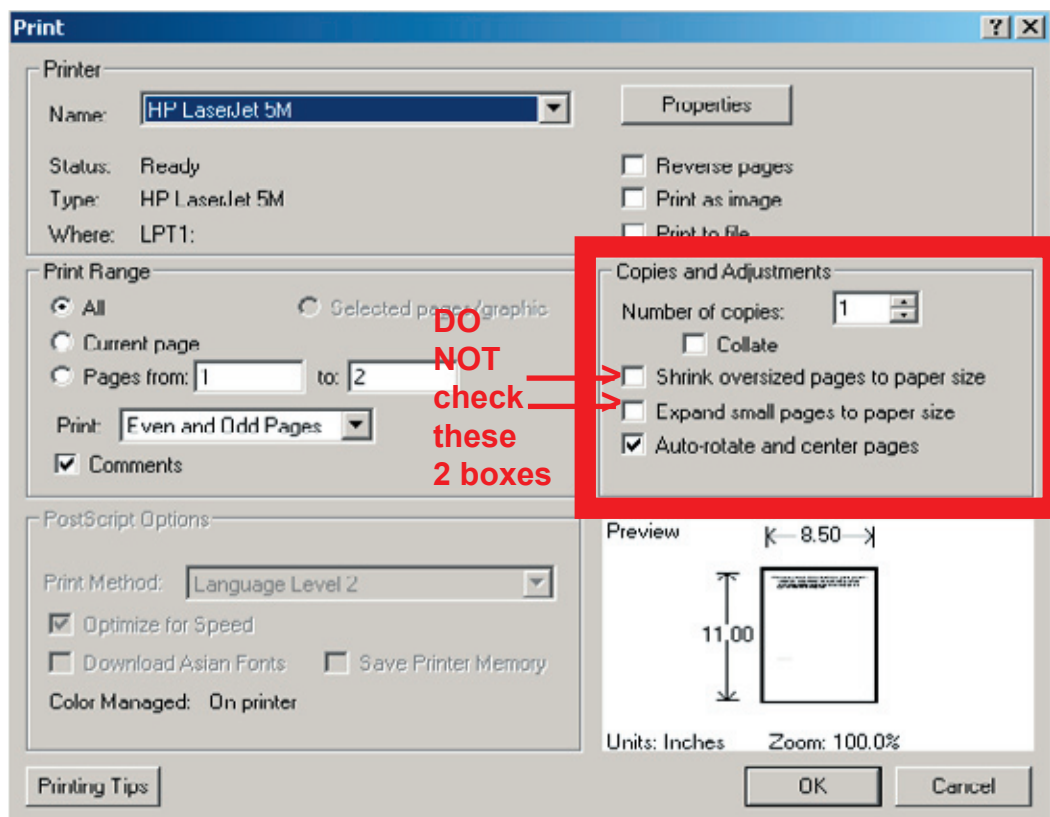


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Chiropractic X-Ray Technician Application Packet

1. 641-033 ... Contents List/SSN Information/Deposit Slip 1 page
2. 641-029 ... Instruction for Registration as a Chiropractic X-Ray Technician 1 page
3. 641-028 ... Application for Chiropractic X-Ray Technician 4 pages

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application



Chiropractic X-Ray Technician

DEPOSIT SLIP

NAME (Please Print)

Revenue Section

P.O. Box 1099

Olympia, Washington 98507-1099

DATE

Please note amount enclosed, and return with your application.

\$

☐ Check

☐ Money Order

DOH 641-033 (REV 2/2006)

1F 0252240000 01183

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Instructions for Registration as a Chiropractic X-Ray Technician

Important Notice: Registration as a Chiropractic X-Ray Technician is mandatory if you handle x-ray equipment in the process of applying radiation on a human being for diagnostic purposes.

1. **Education/Training**—List your educational preparation/training of at least forty-eight hours of classroom instruction.
2. **Personal Data**—All health related professions are regulated under both the law relating to the special profession and the Uniform Disciplinary Act (RCW 18.130). Be sure you have received a copy of the Law Relating to Chiropractic and have read the Uniform Disciplinary Act. For each **yes** answer to the Personal Data Questions on the application, documentation is required.
3. **Applicant's Attestation**—Read carefully before signing and dating.

Please Submit:

- a) Completed Official Application

\$25.00 Nonrefundable application fee

\$25.00 Original registration fee

Note: Make check or money order payable to the Department of Health.

- b) Proof of 48 hours of classroom instruction for X-Ray Technicians and verification of passing a proficiency examination **or** Verification from a National Certifying Agency.

Mail completed application to: Department of Health
Chiropractic Commission
PO Box 1099
Olympia, WA 98507-1099

* Washington state law and Department of Health policy prohibits employees from receiving any gifts, gratuities and/or favors. Any offer of private benefit to an employee that is intended to influence a public decision is bribery and violates federal and state law. (Reference RCW 42.18.320(2)).

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only

VALIDATION:	DATE RECEIVED:
REGISTRATION #:	ISSUANCE DATE:

Registration #

Application For Chiropractic X-Ray Technician

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST	FIRST	MIDDLE NAME
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MAILING ADDRESS

CITY	STATE	ZIP	COUNTY
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NOTE: The mailing address you provide will be released upon public request as it is the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change.

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS) ()	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW) — —
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GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	BIRTHDATE	PLACE OF BIRTH (CITY/STATE)
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Have you ever been known under any other name? ☐ Yes ☐ No

If yes, list full name(s):

2. Education and Training

In the space below, provide your educational preparation/training. An applicant who holds a current active registration, license or certification from a national certifying agency or other governmental licensing agency whose standards for registration, licensure, or certification are equal to or exceed the standards under these rules may register without examination.

NAME OF INSTRUCTOR OR INSTITUTION WHERE TRAINING WAS COMPLETED	HOURS COMPLETED
--	-----------------

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Chemical substances” includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

“Currently” means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.

“Illegal use of controlled substances” means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

- a. the use or distribution of controlled substances or legend drugs? ☐ ☐
- b. a charge of a sex offense? ☐ ☐
- c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

- a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐
- b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐
- c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Applicant's Attestation

I, _____, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state and federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant _____ Date _____

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Washington State Records Center